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ABSTRACT

The report, presented from a nursing point of view, looks at the care of children in European hospitals including official policies, regulations, laws and daily nursing care practices. The first chapter provides a rationale for the study with a review of the literature and a presentation of the conceptual framework of the study. The second chapter looks at previous research into the care of children in hospitals including the effects of a hospital stay on the child and children's reaction to stress. Considered next is what the hospital should offer in the areas of daily care, organization of the hospital unit, emotional support to parents, and emotional support to the child. The fourth chapter outlines the methods and procedures for the study and the fifth details the results. Seventeen recommendations include the following: a parent should be able to care for a child in hospital without losing his or her job or income; policies should encourage alternatives to hospital admission whenever possible; children under 15 should be admitted to children's units only; rooming in facilities for a parent should be provided free of charge; and, every child should have an individual nurse assigned during the hospital stay. (DB)

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care of children in hospital

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Else Stenbak is a Danish nurse who finished her training in 1961. Since then she has received postgraduate training in nursing and public health, both in Denmark and in Sweden. She has held a number of posts in paediatric departments in hospitals in Denmark, and has also had experience in paediatric nursing administration. For a number of years Else taught the principles of caring for children in hospital to hospital personnel as well as to parent groups. In 1979 she published a book on the situation of children in hospital, and has produced more than 25 other publications on this subject.

Lilian Brøgger was born on the Danish island of Fanø in 1950, and trained at the School of Applied Arts. She designs posters and book jackets, works for television and, not least, produces exciting and lavish illustrations for children's books. Lilian uses colours in a fresh and exciting way, dreaming up, composing and shaping her own fascinating pictorial universe in which even the perspectives in the brush-stroke go to make up an original artistic expression. She was deservedly awarded the Danish Ministry of Culture illustrator's prize in April 1985.

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The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health problems of the countries it serves. The European Region has 33 active Member States,[a] and is unique in that a large proportion of them are industrialized countries with highly advanced medical services. The European programme therefore differs from those of other regions in concentrating on the problems associated with industrial society. In its strategy for attaining the goal of "health for all by the year 2000" the Regional Office is arranging its activities in three main areas: promotion of lifestyles conducive to health; reduction of preventable conditions; and provision of care that is adequate, accessible and acceptable to all.

The Region is also characterized by the large number of languages spoken by its peoples, and the resulting difficulties in disseminating information to all who may need it. The Regional Office publishes in four languages — English, French, German and Russian — and applications for rights of translation into other languages are most welcome.

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World Health Organization
Regional Office for Europe
Copenhagen

Care of children in hospital

A study
by Else Stenbak

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Foreword

The care children receive when they are in hospital is of unquestioned importance. To get a general overview of this care in 1982, the WHO Regional Office for Europe asked Else Stenbak to visit selected hospitals in nine countries from the north, south, east and west of the European Region. Else Stenbak is a Danish paediatric nurse and well known expert in this field and this is the report of her findings. It must be borne in mind that it is not intended to be a full presentation of the situation in Europe, but rather a series of local studies that give well documented impressions of the care of children in European hospitals. The subject is, of course, a great deal more complex than could be fully covered by such a survey. For example, time did not allow for the particular case of children who must stay for long periods in hospital to be considered properly. The care of children in hospitals ranges from the very good to the horrifying, and there are many opportunities for levelling up to the best current practice. There is a clear lack of awareness in a surprisingly large number of hospitals of the special need not only to cater for children's technical, medical and nursing needs, but also to minimize the adverse effects of being separated from their families and exposed to frightening experiences that are all too often magnified by the child's lack of forewarning.

It is hoped that this report, with its essentially nursing point of view, will prompt other health professionals, social workers, educators, health administrators, politicians and parents to review the situation of children in hospitals from their own points of view. They could well use this book as a lever to raise the standard of child care in hospitals all over the Region.

J.E. Asvall
WHO Regional Director
for Europe

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1

Rationale for the study

Child mortality has decreased considerably in industrialized countries. With growing technology more diseases are curable, but physical care is not enough to meet the needs of a child in hospital (*1*). Research from the 1960s and the 1970s has shown that children may, for a long time after being in hospital, suffer from a variety of emotional complications due to separation from their parents, isolation and unexpressed anxiety (*2*). Although there have been isolated improvements in the hospital care of children and official policies have been formed in some countries, the existence of hospital procedures and policies that may affect the nursing care and subsequent adjustment of children who have been in hospital has not been systematically examined.

The overall objective of this study was to examine the care of children in hospital. The specific objectives of the study were to:

— gather information on official policies, regulations and laws that govern the hospital care of children;

— gather information on daily nursing care practices in selected inpatient units where children are admitted;

— use non-participatory observation methods to verify and/or to clarify the information gained as above.

A review of the literature

The last five years' literature was reviewed but none of it cited any research that identified the nature or extent of existing laws or policies concerning the child in hospital in Europe. No studies were found that described the daily care practice in secondary care facilities for children in hospital in Europe (*3*). Yet literature concerning the growth and development of children, as well as the literature that addresses the effects of illness and stress on the development of the child, is well recorded (*4*, *5*). Much research has been reported that supports the value of the staff's awareness of the factors that affect emotional adjustment in hospital (*6–9*). Recently, emphasis has been placed on the need for preventive measures to minimize children's reactions after they leave hospital and to emphasize the experience as an event that carries potential for growth and learning (*10*, *11*). Intense emphasis on high technology, reduced nursing staff and increased medical specialization are but a few of the factors that have served to minimize or, in some instances, obscure the psychosocial aspects of being in hospital. In summary, because of the effects of going to hospital on the child, the family and the community, a study of the care children receive in hospital is important and timely.

Conceptual framework of the study

A major goal of paediatric care is to assist and support the growing, changing child so that he may achieve his potential, whatever that may be. Parents, family and community play pivotal roles in this developmental process, and at times, health professionals may have to support those individual and collective efforts.

When a child goes to hospital it interrupts the smooth developmental cycle, and may be a traumatic experience. The ability of the child, family and/or community to adapt effectively to the stress of the child going to hospital will

depend on several things. The physical and psychological reactions of the child and his or her family are crucial. These reactions are, in turn, affected by the kind of care services provided and the nature of the hospital environment. These will be, at least in part, affected by the rules and regulations for the care of children in hospitals.

Viewing the family as a unit, it is evident that the trauma of an illness in one member will always affect the other members and their relationships. Parents can easily transmit their emotions to their child, so if the parents are calm and trustful the child will often be the same. There is strong evidence that parents' emotional wellbeing while their child is in hospital has a positive effect on the child's recovery (*12*, *13*).

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Previous research into the care of children in hospital

During the 1950s, the work of James Robertson (*14*) first focused attention on the possible adverse effects of hospital on children. Since then a body of literature on the subject has been published (*15*, *16*) as researchers have attempted to determine the value of suggested countermeasures. According to their conclusions, the notion was accepted that sending young children to hospital could cause immediate disturbances of behaviour and developmental regression, with possible long-term effects. It has been recommended and emphasized that: (*a*) provisions should be made to avoid separating families and children while they are in hospital; (*b*) attention should be paid to the education of hospital staff; and (*c*) hospital environments should be designed to meet children's developmental needs at different ages. To improve the situation, research findings have been implemented in many parts of the world and guidelines regarding the hospital care of children have been developed (*17–20*). Some countries (*21*, *22*) have official recommendations. The themes that should be considered in the care of children in hospitals usually include the following.

1. Children should not go to hospital, unless it is absolutely necessary. Other options include offering alternatives to hospital care and/or improved home care; establishing outpatient facilities; and providing social security for parents to stay away from work to care for a sick child at home.

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2. Children should not be admitted to adult wards, but to units where play facilities, accommodation for parents and specially educated paediatric staff are available.

3. Children in intensive therapy and isolation have the same need for social contact and support as other children. Satisfying this need requires special consideration.

4. Preparing the child and the family before admission has been shown to be of considerable benefit. The reasons for admission should be explained to the child and the family and they should be informed about the expected treatment and length of stay.

5. Young children who are accompanied by their parents throughout their stay in hospital have less disturbed behaviour on their return home than children who are without their parents. Parents should accompany the child to different procedures, i.e. X-ray and anaesthesia.

6. Discharge should be planned with due regard to both the child's and the parents' convenience.

Effects of a hospital stay on the child

The work of James Robertson emphasized the importance of mothering to young children, and the possible trauma resulting from enforced separation. He pointed out that young children cannot be treated as small adults; rather, they require special care because of their particular vulnerability. Vernon et al. (*23*) studied the effects of going to hospital on a sample of 387 children by means of a questionnaire sent to the parents after the return home. This study confirmed the current opinion that:

> the combination of illness and hospitalization is a psychologically upsetting experience for children in general, resulting in

increased separation anxiety, increased sleep anxiety and increased aggressions towards authority.

In 1975, Douglas (*24*) published a study of the effects of being in hospital, drawing on the material from a longitudinal study of a relatively large age cohort. This retrospective study showed a disturbing association between long or repeated stays in hospital before the age of five (in particular between six months and four years) and increased behaviour disturbances and poor reading in adolescence. The following year, Quinton & Rutter (*25*) published the findings of their replication of Douglas' study which confirmed Douglas' findings.

Effects on the infant

The first recorded instance of the harm done by depriving babies of maternal care is an experiment conducted by Frederik II, King of Germany, King of Sicily and Emperor of the Holy Roman Empire (1194–1250). The King's chronicler, Salimbene writes:

> . . . he wanted to find out what kind of speech and what manner of speech children would have when they grew up if they spoke to no one before-hand. So he bade foster mothers and nurses to suckle the children, to bathe them and wash them, but in no way to prattle with them or to speak to them. For he wanted to learn whether they would speak the Hebrew language, which was the oldest, or Greek or Latin or Arabic or, perhaps the language of their parents of whom they had been born. But he laboured in vain, because all children died. For they could not live without the petting and joyful faces and loving words of their foster mothers (*26*).

Green & Solnit (*27*) describe parents' reactions to what they believe to be a life-threatening illness in the child before the age of two. Twenty-five children recovered physically, but all were left with what is defined as "a vulnerable child syndrome" up to eight years later, being overprotected by their parents who were still anxious that

their child might suddenly die. Long-term psychosocial complications were present in the children in all cases.

Effects on the preschool child

Robertson found that most children, particularly between the age of eighteen months and five years, pass through three phases in the process of adaptation to the stress of being in hospital: protest, despair and denial. Each phase merges into the next and none is sharply demarcated from the others. The phase of protest lasts a few hours to several days, depends upon the child's energy, the quality of care he receives from hospital staff, and whether or not he receives loving care or is left alone. In the phase of despair, the child will be quiet and depressed. He looks very sad and is considerably less active. In denial the child will look cheerful and interested in the environment. He seems to be very happy when relating to the staff. What has occurred in reality to effect this change is that the child can no longer bear the painful fact of losing his parents and prefers to ignore it. If separation has been prolonged, the continuity of the parent–child relationship is interrupted and it may be difficult to re-establish.

Effects on the schoolchild

Even if the child is older he may still suffer from separation from his parents. But he is now also very dependent on his group of peers at school and in the neighbourhood. A study of schoolchildren shows that 13% of a sample of 672 children had a greater need for education after discharge (*28*). School education in hospital is important to help the child keep up with his peers, and time spent with well known materials and books may give some relief from anxiety (*29*).

Effects on the adolescent

Adolescents will show a variety of reactions to going to hospital. Some may cooperate, and some will protest against rules that have to be kept. Some will seem mature and cope

with the stress in an adult way. If the illness or treatment involves disfiguration, loss of functions and altered appearance, this may be very threatening to the development of identity. Emotional outbursts that are usually directed at parents may be redirected towards the staff (*30*, *31*).

Effects on the family

As mentioned earlier, it is difficult, if not impossible, to separate the effects of going to hospital on a child from those on the family, especially when the child is very young. For the parents the admission of a child will often be a potential traumatic crisis, i.e. a situation that is so overwhelming that earlier adaptation mechanisms are not sufficient (*32*). The parents' reactions will vary according to the seriousness of the illness of the child and according to the parents' belief of its seriousness. Aggressive outbursts from parents are well known to hospital staff even if the child is not seriously ill.

When a child suffers from an illness from which the parents do not expect him to recover, the parents' reactions may lead to behavioural problems in the child. Children with chronic diseases may suffer from long-term psychosocial problems if support is not given to the parents (*33*). Parents' reactions to children with burns—which is often seen by the parents to be their fault—may cause severe problems in the child. A study of children with burns and their mothers showed that 81% of 198 children suffered severe disturbances related to their mothers' feeling of guilt, two to five years after the accident (*34*).

Children with long-term or serious illness may cause reactions in their siblings. It is to be expected that some sibling jealousy will develop whenever most of the parents' concerns are with one child. The attention of hospital and nursing personnel is focused on the needs of the ill and few have the time to consider the emotional needs of well children whom they have never met. Parents adapting to the stress of one child being ill may tend to forget the needs of the healthy siblings. As a consequence, feelings of guilt,

jealousy and resentment may cause immediate and acute pain and contribute to long-term personality problems in these children (*35*).

Effects on the community

Short-term as well as long-term effects for both child and family must call for extra attention from social and financial authorities. There seems to be no literature describing the costs to the community of problems that have developed in a family as a result of a child going to hospital. The documentation of problems in these families might encourage the community to be more alert and take preventive measures during a child's stay in hospital. These measures will help to reduce the cost of long-term measures.

Children's reaction to stress

When an organism experiences stress the adaptation will be in three phases: alarm, resistance and exhaustion. When stress lasts for a prolonged time or when the organism cannot provide sufficient internal and/or external resistance to the stressor, some specific reactions will occur owing to increased hormone production in the blood. Various somatic reactions may be seen, i.e. headache, muscle tension and stomach ulcer. Perhaps decreased resistance to infection is the most common reaction in children.

Psychosocial development will be influenced by a stay in hospital. As described by Robertson, one of the reactions may be disturbances in the parent–child relationship. When deprived of play facilities the preschool child in hospital may have problems with the development of autonomy. A schoolchild may become passive and a poor learner after being in hospital, while the adolescent may experience identity problems.

As successful development in later stages will depend on success in the previous stages, it is necessary to evaluate the child's experiences before going to hospital.

3

What the hospital should offer

Studies show that a great number of children go to hospital at some time. About half the children in one European country spend some time in hospital before the age of 15 (*36*); in another 45% have been to hospital before the age of seven (*37*), while in a third country 25% have been to hospital before the age of five (*38*). Furthermore, although it is generally accepted that children should be admitted to paediatric units, in one European country only 35% of children admitted to hospital are cared for in a paediatric unit (*39*).

It has been known since the 1960s that going to hospital can be a difficult experience for a child and many ways have been found to help children cope with it with the minimum of suffering. Yet this knowledge is still very rarely put into practice in the European Region, nor is it reflected in many laws or regulations.

As a result of the Platt report (*40*) one European country is known to have regulations for children in hospital (*21*) and another has regulations for play facilities (*22*). A study on the effects of regulations in one country (*41*) concluded, however, that:

> . . . Although great improvements have been made in the last twenty years children in some hospitals are still experiencing conditions condemned by the Platt report.

Laws are not the only way of effecting change, but in some countries they may be the best way. In others local

institutions may have the autonomy to do as they think best without the support of regulations. Furthermore, where education, time off work and finances are concerned, there have to be laws to enforce these practices, while the issues of rooming-in and preparing children for medical procedures do not require such legal sanctions. For instance, home care programmes as an alternative to hospital care have proved very effective (*42*). It has been shown that negative effects on the child and the family are reduced significantly by home care (*43*). It has also been shown that if parents participate in the care of their child in hospital the costs and the length of stay in hospital can be reduced. According to authorities in this field a stay in hospital should be as short as possible, but whether a child can be discharged when he may still need some care at home will depend on the parents' ability to stay at home. But for parents to care for their child at home or even in hospital they have to be absent from work, and in some cases this can entail reductions in salary and the possibility of losing their jobs unless protective legislation exists.

Since hospital educational and play facilities cost money, their provision will also depend on laws and regulations. The same is true for adequate staffing ratios in children's units, yet many Member States have no laws and regulations for these aspects of the care of children.

It is worth spelling out what is now known about the needs of children who have to spend some time in hospital, before describing in the following chapters how the present study was carried out and what shortcomings it found in the care that children actually receive in hospital today.

Daily care

The overall need of a child is to feel emotionally safe, i.e. to be loved and to belong to someone special. To meet this need, the repertoire of the hospital staff should include knowledge about a child's physical needs and needs created

by the illness itself, along with knowledge of family dynamics, of the mechanisms of coping and adaptation to stress, and of the possible psychosocial risks for the child and the family when a child is in hospital.

Organization of the hospital unit

To secure the quickest possible return of the family to normal after discharge, admission should ideally begin with proper preparation, i.e. preparation geared to the child's developmental age and carried out by people prepared in these skills (*44*). Although it is difficult to prepare a child for an emergency admission, it has been done in some cases; visits by groups of potential child patients have actually been made in practice (*11*, *17*).

Parents should be allowed to visit whenever they like. If they cannot room-in with their child, visiting should be planned according to their convenience. Staff should be trained to know that parents under stress are not always able to ask for permission to visit or to stay, so they should be encouraged to do so if possible. Free visiting also means that the whole family should be allowed to visit. Where rooming-in is allowed, it can be very tiring for a parent, so there should be a parents' room for relaxation and of course, they will have to be given meals during their stay.

As play and school are parts of children's normal life, education and play facilities should be available in the unit. If deprived of play, a child will have no opportunity to work through the frightening experiences of the hospital. An explanation of what is going on is also best understood through play sessions (*45–47*). Play and school facilities should be accessible even when a child is confined to bed or to a wheelchair. When he can, a child will explore his environment. Safety is therefore an important part of the design of a unit. To be cared for by the same personnel is important to meet the needs of the child. Placing children in

intensive therapy and isolation should therefore be done with due regard to the needs of the child.

Financial problems are common when a child goes to hospital, and these should be referred to a social worker.

Emotional support to parents

The overall care plan should be made with the parents. When information and emotional support is supplied to parents, research has shown that children recuperate faster, parents express greater satisfaction with hospital and medical care, and both parents and child are more cooperative (*13*). In the study referred to, information and support was given at specific times identified as "stress-points", i.e. at admission, before blood tests, late in the afternoon on the day before operation, before preoperative medication, before transport to the operating theatre and upon return from the recovery room. Support here includes encouraging the parents to express their feelings orally. Preparation for possible behavioural difficulties in the child and the siblings may be discussed at any time. It may be necessary to refer to the health visitor who may have valuable knowledge to contribute.

Emotional support to the child

When parents are sufficiently supported they should be able to meet most of their child's needs. If the parents for some reason are not able to stay with their child—perhaps because of work or other responsibilities, perhaps because of limited visiting hours—the risks of psychosocial complication in the child may be reduced if the child is assigned to a special nurse or a substitute mother. Bringing well known, beloved toys to hospital and wearing their own clothes may help in maintaining part of children's home milieu.

Whatever a child is going to experience during the stay in hospital must be carefully explained. Oral explanations may not be enough as the child, in general, will not be able to understand abstract explanations. Misunderstandings and misinterpretations may cause great anxiety in the child about what has happened, what is going to happen and why. Here, again, it is important for a child to be assigned to a special person. To express anxiety, a child or an adult needs to feel emotionally safe.

The contribution of the nurse to alleviating the effects of trauma on a child must be geared to the developmental stage of the child and to the characteristics of the trauma. Play as an instrument for communication about the trauma will always be useful and often the only instrument a child can use. During a play session the child may gain some understanding of what is going to happen or get some relief from what has just been endured. Furthermore, play sessions offer a time to relax among well known equipment. Education, too, offers some relaxation, and it is necessary to help the child keep up with peers, which is particularly important for older children.

4

Methods and procedures for the study

Sample

The sample included 24 inpatient hospitals in 9 countries. The countries were chosen to be as representative as possible of the 33 Member States of the WHO European Region. The hospitals were a convenient, non-random sample of easily accessible hospitals in urban areas, that provide generalized care to children from birth to 15 years. No attempt was made to study other institutions that offer specialized care to this age group of children. The findings therefore apply solely to the kind of institution included in the sample.

Questionnaires

Two questionnaires were used to gather data: the official country regulation and law form and the nurse interview form. Both were non-standardized and designed specifically to gather data for this study (see Annex 1).

Official country regulation and law form

The purpose of this questionnaire was to gather data about official national policies, regulations and laws that govern the overall health and welfare of children between birth and 14 years of age when they are admitted to hospital as inpatients. The questionnaire is a 13-item semi-structured

interview. The purpose of the interview was to verify in English, with an official government representative, the contents of written policies, regulations and/or laws, as most such documents are in the country's national language. The questionnaire took about 45 minutes to complete.

Nurse interview form
The purpose of this questionnaire was to gather data about daily care practice in selected inpatient hospitals where children from birth to 15 years are admitted. The questionnaire is a 27-item semi-structured interview with a first level nurse, to identify the care given to the child and family. The purpose of the interview was to clarify ideas that may be impossible to obtain through a written questionnaire. The questionnaire took about 60 minutes to complete.

Research design

The study is an oral descriptive survey using a semi-structured interview and non-participatory observation to collect data on the care of children from birth to 15 years in 24 inpatient hospitals in 9 countries.

Procedure

A letter to the ministry of health in each of the nine countries introduced the study and asked the ministries to arrange the following for the researcher:

— an interview with a government representative;

— visits to two or three general hospitals where children from birth to 15 years are admitted; these visits would include an interview with a clinical nurse and non-participatory observation by the researcher.

Assumptions

Six assumptions were made in the design of this study:

1. that the nurse would be able to report on the patterns of care and conditions of the clinical setting accurately and honestly;

2. that the officials' understanding of the regulations and laws would actually reflect those regulations and laws;

3. that the official country regulation and law form does, in fact, reflect relevant components of the country's regulations and laws;

4. that the nurse interview form does, in fact, reflect relevant components of the care practices as seen by the nurse;

5. that a group of paediatric nurses has a common core of behaviour towards children, and that these characteristics can be described through an interview;

6. although all the interviewees would know that data were being collected for inclusion in a study, this factor would not necessarily affect their behaviour. Nevertheless, the fact that a study was being conducted could have affected their report of the situation.

5

Results of the study

The sample for the study consisted of 24 inpatient hospital units for children in nine countries, representing the north, south, east and west of the European Region. These countries are identified by a country code only, for the sake of confidentiality. Of these units, 15 are located in paediatric hospitals, 7 are located in general hospitals, and 2 are actually adult wards that also admit children (see Table 1).

As can be seen in Table 1, 4581 beds or 47.1% of the total number of beds in the units visited are in hospitals designed specifically for children, while 3532 beds or 36.3% are located in general hospitals.

Official policies, regulations and laws about children in hospital

As may be seen from the following tables, data related to policies, regulations and laws were not always available. The reason for this varied, but in most cases the data were not available either at the ministry or at all. Except where indicated otherwise, country No. 4 provided no data on policies, regulations and laws.

Originally, the proposed age limits were from birth to 12 years, but this could not be strictly adhered to because the upper limit in some units is set at 15 years. Thus, the data

Table 1. Type and size of hospitals visited

Country and unit	No. of centres visited	Number of beds	
		Paediatric hospital	General hospital with paediatric unit
1	3		
a		505	—
b		80	—
c		450	—
2	4		
a		—	304
b		125	—
c		—	362
d		—	480
3	3		
a		160	—
b		200	—
c		200	—
4	3		
a		535	—
b		560	—
c		—	614
5	3		
a		400	—
b		150	—
c		—	200
6	1	500	
7	3		
a[a]		—	—
b		—	848
c		—	724
8	1	550	
9	3		
a[b]		—	—
b		41	—
c		125	—
Total	24	4581	3532

[a] This is a general hospital with 1500 beds. Although a paediatric unit is available, children are still admitted to an adult unit. It was the adult ward that was reviewed.

[b] This hospital had 108 beds and no paediatric ward. Children were therefore admitted to an adult unit.

were collected using 15 years rather than 12 years as a ceiling age.

The interview

A semi-structured interview was conducted in nine ministries of health, one in each of the countries, and in all cases the interviewee was designated by the health authorities. In four countries, the interviewee was responsible for maternal and child health care in that country. In three countries, the interviewee was a nurse, in one country a statistician, and in one country a medical research supervisor.

The time required to conduct the interviews ranged from 30 minutes to two hours with an average interview time of one hour.

The results

The proportion of children under 15 years of age admitted to hospital each year ranges from 7.9% to 9.2% of all children in this age group. One country gave a total number of admissions, but was unable to calculate a percentage figure. Five countries could provide no figures. In country No. 3, adult units cannot admit patients under the age of 12, while in country No. 4 the age limit is 16.

Although exact figures were not available of the distribution of children between paediatric units and non-paediatric units, the informants estimated the percentages admitted to each type of service. Admissions to paediatric units vary from 35% to 100% (see Table 2).

Countries Nos. 1 and 7 indicated that the allocation of children to either kind of unit rests with the consultant (physician). Country No. 2 decides on the basis of the type of therapy (treatment) available in the paediatric service. Countries Nos. 3 and 6 use distance and availability as the two determining factors. Countries Nos. 5, 8 and 9 had no data available.

Countries Nos. 1, 5, 8 and 9 indicated that outpatient clinics are used whenever possible as an alternative to

Table 2. Number and percentage of children admitted to paediatric units and non-paediatric units in hospitals in nine countries

Country	No. of children admitted	Percentage of these children admitted to:	
		paediatric unit	non-paediatric unit
1	807400	68.3	31.7
2	266288	84.0	16.0
3	ND	35.0[a]	65.0
4	ND	ND	ND
5	40992	ND	ND
6	ND	ND	ND
7	100100	38.1	61.9
8	ND	100.0[a]	0.0
9	ND	ND	ND

ND = no data available.
[a] Estimated.

hospital admission; countries Nos. 3 and 7 reported the same preference, but added that such facilities are not always available. Country No. 6 reported having outpatient facilities in the planning stages, and country No. 2 is experimenting with specialized outpatient clinics.

Parents are not permitted by law to stay away from work to take care of a sick child in countries Nos. 1, 2, 6 and 8. Country No. 3 offers five days per year for each parent; this service is paid for by social security or health insurance. In country No. 4, public employees are permitted 6 non-consecutive days per year for each parent for "uncomplicated cases", and 15 consecutive days for each parent per year for a "serious case". In both instances, the costs are covered by the employer. Country No. 5 allows 30 days a year, paid by the employer. In country No. 9, three days are permitted, and costs are covered by the employer. In country No. 7, no upper limit was indicated; most parents are paid by the employer for the first day of the child's illness only.

In countries Nos. 1 and 2, the current policy regarding participation by parents in their child's stay in hospital is to encourage the parents to feel welcome. Country No. 3 noted only that paediatric units are opening up to parents. Country No. 5 reported a law that entitles the child to have the presence of his or her parents. Country No. 6 reported plans for the building of new hospitals which were viewed as "limited improvements". Countries Nos. 8 and 9 have no regulations, policies and/or laws.

The average length of stay for the child in hospital in the nine countries varies from 4.8 to 13.0 days. The overall average length of stay is 10 days, with a median of 10.5 days. Three countries (Nos. 4, 6 and 9) had no data available (see Table 3).

Countries Nos. 7 and 8 have no policies, regulations or laws about the number of visiting hours allowed per week, while country No. 5 has a law stating that parents are entitled to be with the child. Countries Nos. 1 and 2 have regulations recommending the maintenance of family links. Country No. 9 has a policy of three hours twice a week while two countries (Nos. 3 and 6) are working on plans to expand visiting hours, although all the units visited in those countries already have 24-hour visiting.

Table 3. The average length of stay for a child in hospital in nine countries

Country	Days
1	4.8
2	10.4
3	12.7
4	ND
5	11.3
6	ND
7	7.9
8	13.0
9	ND

ND = no data available.

With regard to who can visit (irrespective of whether there are set visiting hours) in all countries parents are the designated allowable visitors. Countries Nos. 1, 2, 5 and 6 generally allow families and siblings. Country No. 7 has no policy, and countries Nos. 3, 8 and 9 allow no visitors other than parents.

Three countries (Nos. 5, 6 and 9) have no policies, regulations and/or laws on the existence and extent of schooling in hospital, four reported a law for education (Nos. 1, 3, 8 and 9), and one a regulation (No. 2). Country No. 7 has a law saying that a child must receive education when he is ill.

Regulations recommend play programmes in countries Nos. 1 and 2. Countries Nos. 3, 6 and 8 noted the presence of such programmes but no policies. Country No. 5 has no programme, and no data were available from countries Nos. 7 and 9.

The patient/nurse ratios also vary from country to country, with two countries (Nos. 3 and 4) reporting no data available and countries Nos. 5, 6 and 7 with reportedly no policies, regulations and/or laws. Actual reported ratios vary from 1 child per 1.5 nurse (country No. 1) to 15 children to 1 nurse in country No. 8.

Information on daily care practice

The interview

To gather data on daily care practices in selected inpatient units where children are admitted, a semi-structured interview was conducted in 24 units, all of which were selected by the ministries of health in the countries visited. The number of units in the countries varied from one to four, and of the respondents interviewed four were not nurses.

The time required to conduct the interviews ranged from 25 minutes to four hours with an average interview time of

Table 4. Years of education and experience of interviewees

Country and interviewee	Paediatric experience (years)	Paediatric education (years)
1		
a	4	1
b	(1 month)	1
c	20	1
2		
a	3	1
b	3	1
c	10	1
d	21	1
3		
a	1	ND
b	6	ND
c	11	ND
4		
a	10	0
b	20	0
c	28	0
5		
a	(2 months)	0
b	0[a]	0[a]
c	0[a]	0[a]
6		
a	0[b]	0[b]
7		
a	3.5	(2 weeks)
b	3.5	(10 hours)
c	5	0
8		
a	ND[c]	ND[c]
9		
a	9	ND
b	18	ND
c	33	ND

ND = no data available.
[a] Hospital administrators, not nurses.
[b] Matron of the hospital.
[c] Interview included medical director and three nurses.

one hour. During the interviews the nurses acknowledged the need for paediatric education. The training and experience of the interviewees are shown in Table 4.

The results

Characteristics of hospital units visited

Of the units visited, 15 are located in children's hospitals while 9 are situated in general hospitals that offer 1–16 specialties.

In 14 of the units visited, the ceiling age for admission is 14 or 15 years. Three of the units admit children up to the age of 18 years, particularly in cases of chronic illness.

Three units in country No. 5 have a ceiling age of 10 years for paediatric patients. One unit specializes in the newborn, while two specialize in the care of toddlers. One non-paediatric unit admits children up to the age of 8 years.

The number of beds in the units varies from 16 to 49 with an average number of 26 beds per unit. No data were available on the number of beds in three units, because the data provided applied to the whole hospital.

Preparation for going to hospital

The preparation of the child before admission is shown in Table 5. It should be noted that one country (No. 7) invites healthy children in groups as a preventive measure to prepare them for a possible unplanned admission.

Parents' involvement

The admission of parents is encouraged by 11 units, while 9 units allow admission only if the parents ask for it. Four units do not allow parents to stay.

When parents are allowed to room-in, 16 units indicated that a bed is offered while 18 units provide meals (which in 7 cases have to be taken in the canteen). Special rooms for parents are available in 5 units.

It should be noted that in country No. 3 parents are charged a fee for their stay. Sometimes the amount covers the cost of food and in some cases, parents are expected to pay the full price for a hospital bed (about US$100–150/day). Two units in country No. 9 have two parents' rooms

Table 5. Preparation for going to hospital

Country and unit	Leaflet mailed beforehand	Leaflet given after admission	Invitation to visit unit	No preparation
1				
a	+	+	–	–
b	+	+	–	–
c	+	+	–	–
2				
a	+	–	+[a]	–
b	+	–	–	–
c	+	–	+[a]	–
d	+	–	–	–
3				
a	–	–	–	+
b	–	–	–	+
c	–	–	–	+
4				
a	–	–	–[b]	–
b	–	–	+[c]	–
c	–	–	–	+
5				
a	–	–	–	+
b	+	–	–	–
c	+	–	–	–
6	–	+	–	–
7				
a	+	+	+[a]	–
b	+	+	+[a]	–
c	+	+	–	–
8	–	–	–[b]	–
9				
a	–	–	–	+
b	–	–	–	+
c	–	–	–	+
Total	12	7	5	8

+ Yes.
– No.
[a] Invited by leaflet.
[b] Prepared in outpatient clinic.
[c] Invitation given in outpatient clinic.

each; visiting hours are one hour twice a week for all other children admitted.

Parents are informed about the nursing care plan for their child in 11 units at the instigation of the nurse and in 13 units only at the request of the parents.

Two units in country No. 9 do not give information to parents outside a special hour. In all other units contact between parents and nurse is possible at any time. In country No. 3, parents have to give written permission for treatment when the child is admitted, at which time information is given. One unit in country No. 2 displays a sign at the entrance telling parents which nurse will try to contact them that day. One unit in country No. 5 holds weekly information meetings for parents.

When parents room-in or stay for several hours a day, 18 units encourage them to dress and feed their child. Fourteen units encourage parents to be present during medical procedures, such as X-rays, blood tests, etc. Four units encourage parents to accompany their child at medical procedures outside the unit, and one of these also allows parents to be present when anaesthetics are given.

If parents do not visit a child in hospital when allowed, all units call, write or contact a social worker to make home visits. All the units stressed that this is rarely necessary and the unit in country No. 6 said it had no home visit plans as it was never necessary. Visiting hours are shown in Table 6.

Fifteen units claim to attempt to prepare parents for possible behaviour problems in their child. Ten units also prepare the parents for possible sibling problems. In all cases where this kind of preparation is provided, it is described as part of an ongoing process during the child's stay in a unit.

Play areas, school rooms and safety measures

Seventeen of the units have play rooms for children. Fifteen units have school rooms, which are not for the exclusive use of the paediatric unit, but for the whole hospital. Twenty-three units keep toys for the children. Access for children in wheelchairs and beds is not possible in one play room and

Table 6. Number of daily visiting hours to children in 24 units

Country and unit	No. of visiting hours (daily)
1	
a	24
b	24
c	24
2	
a	5 1/2
b	9
c	5 1/2
d	8
3	
a	24
b	24
c	24
4	
a	8
b	5 1/2
c	7
5	
a	7
b	24
c	8
6	24
7	
a	24
b	24
c	24
8	2
9	
a	0[a]
b	0[b]
c	0[b]

[a] No visiting allowed at all.
[b] Visiting hours are one hour twice a week.

in one outdoor play area. Outdoor play areas are available in thirteen of the units.

Countries Nos. 1 and 6 ensure protection at staircases, and countries Nos. 1, 2, 3, 7 and unit b in country No. 4 reported protection at the windows. Country No. 7 and unit b in country No. 3 use high door knobs and unit c in country No. 3 keeps doors to rooms and wards locked with the nurse holding all the keys. Unit c in country No. 4 puts lids on toddlers' beds.

Isolation

In case of a need for special care and/or for isolation purposes, 16 units have staff who can provide care for isolated as well as non-isolated children at the same time. Four units sometimes place the child outside the unit in case of possible contagion, while eight units insist on placing the child outside the unit in such cases.

Role of social workers and health visitors

Countries Nos. 1, 2, 4, 5, 6 and 7 indicated that financial problems related to admission of the child are referred to a social worker. Social problems in the family are referred to the social worker in countries Nos. 1, 2 and 9. In countries Nos. 3 and 8, no social worker is available in the hospital, although in country No. 3 a social worker may be called from outside the hospital.

To prepare a child for discharge, units in countries Nos. 1 and 2 have planned meetings weekly or daily with the health visitor. In country No. 2 a report is written by the health visitor on admission and the hospital sends a report to the health visitor on discharge. Countries Nos. 3 and 4 have no health visitor available, though unit c in country No. 4 has a health visitor because there is a relatively large local immigrant population. Countries Nos. 5 and 6 have no health visitor available, and country No. 7 indicated that a written report to a health visitor or school health nurse is forwarded on discharge. Countries Nos. 8 and 9 admit from and refer back to paediatric outpatient neighbourhood clinics serviced by a paediatrician and paediatric nurse. Thus, 11 of the units cooperate with health visitors, while 13 of the units do not have access to health visitors as health visiting is not common practice in those countries.

Provision for emotional, social and educational support of the child

Concern for the emotional support of the child in hospital is reflected in a number of ways. Assignment to a specified

nurse was the usual practice in half the units, while all but one of the units allow the children to bring their own toys. Nineteen units encourage the children to wear their own clothes while in hospital.

Table 7 shows the way children are prepared for medical procedures such as blood tests, X-ray, anaesthesia and injections. Two units show anaesthesia equipment but do not offer preparation before any other procedures.

Seven units have special play programmes after medical procedures. One unit in country No. 1 works very closely with play leaders: children draw pictures and/or write essays. Two units in country No. 2 organize special play in the play room; one unit in country No. 4 organizes special play on an individual basis. All units in country No. 7 organize special play after medical procedures. Country No. 8 lets the child play but has no special programme.

It was found that units vary in the educational personnel provided. Kindergarten teachers are assigned to 11 units while three units may call on kindergarten teachers who are assigned to the hospital as a whole. Eleven units can call on school teachers who are assigned to the whole hospital and not exclusively to any special unit. Table 8 shows the number of teachers assigned and for how long. It should be noted that in country No. 2, education services are paid for by the hospital. In all other cases education is paid for by the education authorities. Country No. 7 has a law that stipulates that children must receive education after three weeks of illness.

Suggestions for change

In a final section of this interview respondents were asked for suggestions for changes. Their suggestions are presented by country and unit below.

Country No. 1

a. Intensive therapy inside the unit; home care; health visitor/ liaison nurse.

Table 7. The kind of preparation given to children for planned medical procedures

Country and unit	Oral explanation	Books/ pictures	Puppet play	No preparation
1				
a	+	–	–	–
b	+[a]	–	–	–
c	–	–	+	–
2				
a	–	–	–	+
b	+[b]	–	–	–
c	+[b]	–	–	–
d	–	–	–	+
3				
a	–	–	–	+
b	–	–	–	+
c	–	+	+	–
4				
a	–	+	–	–
b	–	–	–	+
c	–	–	–	+
5				
a	+	–	–	–
b	–	–	–	+
c	–	–	–	+
6				
7				
a	+[c]	–	–	–
b	–	+	+[c]	–
c	–	+	+[c]	–
8	+	–	–	–
9				
a	–	–	–	+
b	–	–	–	+
c	–	–	–	+
Total	7	4	4	12

+ Yes.
– No.
[a] Parents are present during preparation.
[b] Anaesthesia equipment shown, no other preparation given.
[c] All kinds of equipment shown.

Table 8. Number of kindergarten teachers and school teachers assigned to the units and the number of hours they work per week

Country and unit	Kindergarten teachers		School teachers	
	Hours	Persons	Hours	Persons
1				
a	37.5	1	10	1
b	37.5	1	–[a]	1
c	37.5	1	37.5	1
2				
a	40	1	15	1
b	120[b]	3[b]	0	0
c	40	1	1	1
d	72	2	0	0
3				
a	0	0	0	0
b	0	0	0	0
c	0	0	0	0
4				
a	0	0	0	0
b	0	0	–[a]	1
c	0	0	0	0
5				
a	–[a]	7[b]	0	0
b	–[a]	6[b]	0	0
c	0	0	0	0
6	0	0	0	0
7				
a	0	0	–[a]	–[a]
b	60	2	–[a]	–[a]
c	40	1	–[a]	–[a]
8	15	1	–[a]	–[a]
9				
a	0	0	25	1
b	42	–[a]	0	0
c	31	–[a]	0	0

[a] Teacher present, no data available either on how long for or how many.
[b] Teacher assigned to the hospital, not only to unit.

b. No suggestions.

c. Paintings on the ceiling in the treatment room; washable, attractive gowns for theatre instead of white ones; educational materials for paediatric nursing; emphasis on child development in education; emphasis on child developmental teams.

Country No. 2

a. More homely environment; need to educate parents about their child's emotional needs.
b. Siblings should be allowed to visit; rooming-in; more attention to immigrants.
c. Outpatient clinics with own staff, not adult outpatient as now.
d. A new hospital; visits by siblings more often and by school friends.

Country No. 3

a. Rebuilding; more education in medical treatment; more staff, more time for the children.
b. More staff so it would be possible to assign a child to no more than three people; continuing education of staff.
c. Own play room.

Country No. 4

a. More space; more private rooms; better care for adolescents; more time so examinations "would not be so cruel".
b. Occupational therapy staff; more colours in the décor.

Country No. 5

a. Basic training in human relationships, infant development, interview skills for nurses, nursing care plans, the importance of a child's family background.
b. No data.
c. Better conditions in the isolation unit; better equipment; better beds; more nurses; kindergarten teacher.

Country No. 6

More staff; better accommodation for parents; play rooms; play leaders; teachers; postgraduate education for staff.

Country No. 7

a. Kindergarten teacher; bigger play room.
b. Rooms for parents; rooms for in-service education.
c. Permission for parents to accompany children to anaesthesia; outdoor play room; bigger isolation rooms; breast-feeding rooms for mothers; admission of parents; better nursing care plans; more primary nursing.

Country No. 8

Solve visiting problems: if the mother is ill, the child may receive no visitors.

Country No. 9

a. Bigger play room; television programme with fairy tales.
b. No wishes.
c. More cleaning staff.

In summary, 20 units expressed a need for environmental changes, i.e. more rooms for parents, rooms for in-service education, outdoor play area and more colours. Seventeen units expressed a need for organizational changes, i.e. more staff, siblings to visit, more attention to immigrants and adolescents. Two units suggested alternatives to hospital care, i.e. home care and health visitor/liaison nurse. Five units suggested more staff in-service education in human relationships, child development, nursing care plans and nursing interviews.

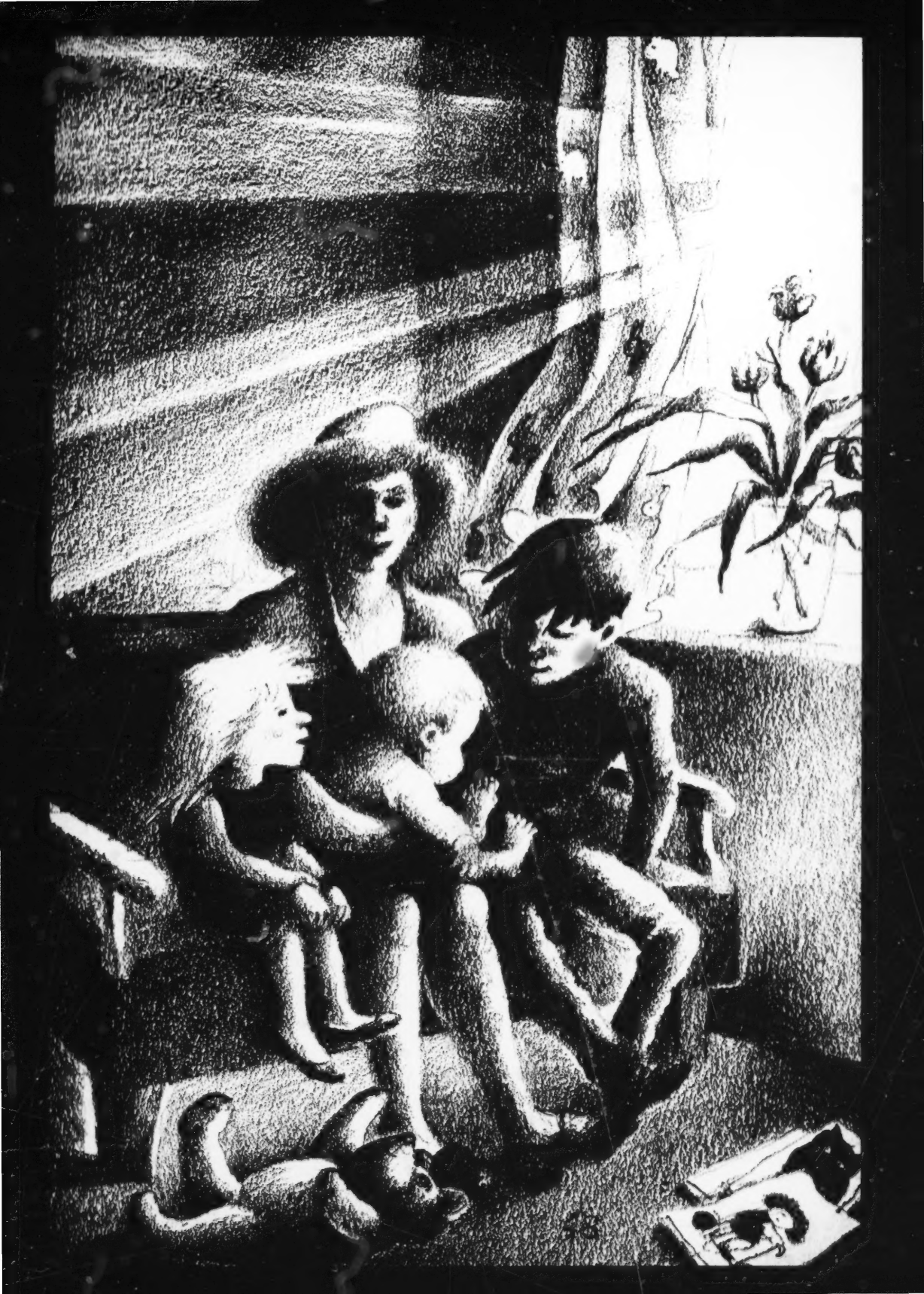
Non-participatory observations of hospital units

The third objective of the study was to verify and/or to clarify the data through non-participatory observation.

The interviewer was escorted when possible before the interviews by the respondents. Written reports on the observations were completed after the visit. The observations were in no way expected to be comprehensive. Rather, the intent was to gather impressions to support the data gained through the interviews. In many cases an invitation was extended to see the whole hospital.

Country No. 1

a. Parents at almost every child's bedside; two children brought back from surgery alone.
b. Parents at almost every child's bedside; a parent preparing a meal with kitchen equipment in a cubicle for a child in isolation; a very good preparation programme with dolls and pictures before X-ray; sand bags shaped as frogs.
c. Parents at almost every child's bedside; well planned care; met health visitor at her daily meeting.



Country No. 2

a. Very clean place; newborn babies in a row with no mothers.
b. Two parents in the unit; team nursing; nursing care plans; overheard remarks that "parents upset the children" and that although there is free visiting in the neonatal unit, it is too hot to stay for more than half an hour so some mothers even come twice a day.
c. Very clean and tidy; in an almost empty unit one three-year old alone in a cubicle with an intercom.
d. Sign with name of nurse in charge at the entrance; a few parents in the unit; play room tidy with no children; a special room, designed for the work of a play therapist, wonderfully equipped with all kinds of play materials, in the unit. The therapist is educated to solve psychosocial problems in families through play. The families are referred to him by the paediatrician. No other children have access to the room.

Country No. 3

a. A few parents in the unit; none in the neonatal unit; nurse supervisor washing the floor.
b. Many parents present; good contact between nurses and parents; team nursing.
c. Not many parents to be seen; children playing in the corridor.

Country No. 4

a. A hospital with wallpaper; different colours, different animals for different ages; pictures low where children could see them; special lounge for adolescents, away from play room; parents constantly contacting nurse; nursing care plans; cubicles for smaller children, all with a bed and a cupboard for mothers; overheard remark that it was necessary to have the parents here.
b. Five parents' rooms with parents in, no parents elsewhere; parents allowed at X-ray if they are curious about the examination; curtains; plants.
c. Five nurses relaxing in nurses' station during interview; three infants crying; all children isolated (0–3 years); very few toys; lids on beds "for safety"; overheard remark that it creates too much work to let parents care for their children, and that the same care is given to all the children as they are all the same age.

Country No. 6

Big play rooms have been converted into patient rooms; a very well organized place; chairs can be folded out as beds for parents at night by each child's bed; parents everywhere; crowded place; big day hospital for 50 patients a day.

Country No. 7

a. Unit only for children; staffed with paediatric trained nurses; some parents present; children's drawings on a special board at each child's bed; pictures of nurses, with a name label; beds in different colours.
b. Parents' room is the unit's kitchen; corridors filled with interesting looking things made by the children; lots of colours and toys; lots of parents; trays with equipment for preparation before any possible medical procedure.
c. Many parents; pictures of nurses; two rooms occupied with geriatric patients; overheard remark that this arrangement had to be accepted if they were not to take nurses away.

Country No. 8

No parent to be seen; pictures on the wall half a metre over an adult's head; no colours; very few toys; no visiting allowed of children under one year (traumatology), the reason given that they would jump about in bed then and spoil the surgery. No visiting allowed in the neonatal unit, or the unit for infectious diseases and oncology, the reason given that when a child has to adapt to sickness and treatment, parents are too much to cope with. Infants swaddled; toys not allowed under the age of two months.

Country No. 9

a. No visits allowed; average length of stay two weeks; toys in cupboards; infants tied at both hands and feet, to prevent them spoiling their surgery.

Three nurses relaxing in the nurses' station during the interview; I was told to leave my coat and bag before entering the unit and to put on a white coat and plastic "shoes". Despite this the measures against infection were inconsistent.

Two children age three or four years each in a corner with their backs to the corridor silently rubbing their hands against the wall.

b. Two parents' rooms with parents in; no parents elsewhere; lots of toys in doctor's office, but it appeared that they were to look at and not to be touched.
c. Silent children in school rooms although they were disturbed when I was shown around; staff laughed at my questions; two parents present in parents' room, none elsewhere.

6

Analysis and discussion

Official policies, laws and regulations

Hospital admission

About half the children in the European Region spend some time in hospital. To ensure the positive adaptation of the child to being in hospital it is important to have policies, perhaps even supported by laws and regulations, concerning the admission of children to hospital. In the study, it was found that five out of the nine countries do not even have the minimum of information such as the number of children admitted to their hospitals. Furthermore, although it is now an accepted notion that children should be admitted to paediatric units, four countries do not maintain statistics on whether children are in fact admitted to children's wards or adult wards. From the data collected in this project it is possible to estimate that about 65% of the children in the countries surveyed continue to be admitted to adult units. There is a great lack of awareness of how many children are admitted, where they are admitted and what alternatives there are to admission.

Parents' involvement

The importance of parental involvement in a child's stay in hospital has been well documented. To be involved, parents must be permitted time away from their everyday work. Most of the countries surveyed, however, have no such provision. Only one country has a law entitling a parent to

be present and two countries have regulations recommending that family links be maintained while children are in hospital. Since studies show a shorter hospital stay if parents are involved, provisions allowing parents paid leave from work can still be cost-effective.

In hospital

Although it is recognized that children should stay in hospital as briefly as possible, the average length of stay in the countries surveyed ranges from 4.8 days to 13.0 days. There is no apparent official policy encouraging the early discharge of children from hospital. Indeed, in two countries with a longer than average stay, hospitals receive funds only for filled inpatient beds thus encouraging longer rather than shorter stays.

In spite of the importance of liberal visiting hours for children, only one country has a law entitling parents to be present. In most other countries visiting privileges are decided by the hospital or by informal agreements. As a result, the observations in this study revealed wide variations in visiting hours and frequent attempts to see children outside the stipulated hours.

Few countries guarantee education or play for children in hospital by law. Health laws in one country and education laws in three countries provide for the education of children in hospital. Only two countries have regulations for play programmes.

The quality of care of children in hospital will obviously be significantly influenced by the availability of nursing staff. Only four countries, however, have policies on nurse/child patient ratios. Furthermore, these ratios vary widely among these countries, and most of the countries surveyed have no official policies or regulations about nursing staff ratios. Under these circumstances it is not surprising that the observations of the investigator support the notion that in many of the institutions surveyed the overall wellbeing of the child is not being identified or effectively catered for by staff.

Daily care practices

Nurses' education

To meet the needs of a child in hospital, nurses must be knowledgeable not only about the physical needs of the child but equally importantly about the psychosocial needs of the child and family dynamics. This clearly requires basic nursing education in paediatrics. Of the 20 nurses interviewed in this project, 7 had a basic nursing education that included paediatrics, 6 were nurses specializing in the care of children with no training in adult nursing, 2 were nurses trained in adult nursing with no more than two weeks of paediatric training, while 5 were nurses educated in adult nursing with no paediatric training at all. This paucity of training in paediatric nursing may at least partly explain the attitudes revealed by some of the nurses during the interviews and observation. Some nurses viewed parents as an interference causing interruptions in their work. Some nurses' understanding of the psychological needs of the child appeared to be at best minimal.

If it is agreed that to care for a child a nurse must have a paediatric education, while to care for the family the nurse must also have an education in adult nursing, then only 7 of the nurses interviewed reached that goal.

Organization of the hospital unit

To guarantee the quickest possible recovery of the child and family after hospital discharge, both the child and the family should be properly prepared before hospital admission. Despite the well documented positive effects of such preparation, only half the units visited prepare children before admission and only two of the units prepare children and families in their catchment area for possible unplanned admissions.

There are 30 years of research results that stress the need for contact between the child in hospital and his family. Despite this, only 11 of the units visited offer free (24-hour a day) visiting while the rest of the units offer an average of

5 hours daily and one unit has no visiting whatsoever. Research also shows the importance of siblings, yet in some of the units siblings have to be over 15 years of age before they can visit. This partial or complete barrier to siblings visiting often also extends to other family members beyond the parents themselves and/or to friends from school or the neighbourhood.

Ideally a parent should be allowed to be admitted to the hospital with the child. Although 20 of the units visited allow admission of parents, only 11 positively encourage the parents to be admitted; 4 of the units visited do not permit parent admission at all. When parents are allowed to be admitted they must of course have their own needs met in the hospital; 18 of the units provide meals for parents although this is often paid for by the parents in the staff canteen. Furthermore, in one third of the cases there was no bed offered to the parent. Most European hospitals were built before it was known that parents' presence with a child in hospital was important and therefore special rooms for parents were not provided. This is often used as an explanation. But alternative solutions can be found, for example in some hospitals a chair that folds out at night into a bed is provided for the parent. It is also true that in some countries, parents are charged for the hospital stay and this may be beyond the parents' means.

Research has shown the importance of play facilities for the child in hospital, not only to provide continuity in the child's daily life but also as an important opportunity for working through the frightening experiences in hospital; 17 of the units surveyed have a play room but very few also have an outdoor play area. School rooms are also essential to provide continuity in children's daily life as well as to allow them to keep up with their education; 15 of the units visited have a school room but there are sometimes problems of access, particularly for children in beds and wheelchairs.

Another reason for having children admitted to children's wards is to provide a safe environment. This

means that paediatric wards need special safety measures. In only four of the nine countries visited are there special safety measures at the windows of all the units where children are in hospital. Locked doors or doors with handles high enough to be out of the reach of younger children were rarely seen in the units visited. There is thus a need to increase safety measures in hospitals with children, but at the same time to bear in mind the psychosocial effects on children of being locked in.

It is most important for the child in hospital to have continuity of care, with the same staff and the same substitute mother during the stay. If the child is found to need intensive care and/or isolation, two thirds of the units visited are able to provide this in the same unit but one third have to transfer the child to another unit with different staff.

Because social and/or financial problems may often arise in a family if a child is in hospital it is important to have a social worker available; 7 of the units visited do not have a social worker available for such assistance.

Emotional support to parents

Research has shown that children recover faster and parents are more cooperative when the parents are given emotional support while their child is in hospital. This support includes giving information and encouraging the parents to discuss their feelings. In 11 of the units visited, the nursing staff is responsible for initiating contact with parents to inform them of the progress of their child; 13 of the units, however, only give such information when the parents themselves ask. Some units found that it helped in giving parents information if a special time was made available for this purpose during the day. All the units visited except two are willing to give information 24 hours a day, while two units visited will only do it one hour a day. One unit has a sign at the entrance telling the parents which nurse is available that day for information and another unit has weekly information meetings with all the parents.

In addition to receiving information, it is important for the parents to participate in the actual care of the child while he is in hospital, as this has been shown to speed the recovery and prevent future problems in the child and family. Three quarters of the units encourage parents to dress and feed their child, but since only half of the units have free visiting the parents are often not present during feeding and dressing time; 14 of the units encourage parents to be present during medical procedures although only 4 encourage the parents to accompany the child to procedures outside the unit. Only one unit encourages parents to accompany the child when anaesthetics are given. Since these procedures are all known to be most stressful parents should have a greater opportunity to participate in them.

The urgency of the situation when parents do not visit their child when allowed is recognized by all units surveyed. All the units indicated that if this occurs they have some means of contacting the parents to find out why they have not visited.

Since it is well known that going to hospital may create future problems for the child, as well as for the siblings and other family members, it is strongly recommended that the family should be prepared for such problems while the child is still in hospital. Some 15 units surveyed prepare the family for possible future behaviour problems in the child, but only 10 of these units also prepare the family for possible difficulties with the siblings.

The community-based health visitor (or public health nurse) is an important member of the health team for the family with a child in hospital. Three countries in the survey have well planned cooperation between the hospital and the health visitor, and two other countries have a paediatric polyclinic network that cooperates with the hospital both before and after the child goes to hospital. The remaining three countries in the survey, however, do not have these links outside the hospital except in very special cases.

Emotional support to the child

The importance of assigning each child to a particular member of staff for care has been shown by careful study. Such continuity of care is important not only to the child but also to the parents, who benefit from knowing that a particular person is concerned about their own child. Nevertheless, half of the units surveyed do not have a system for assigning a particular person to the child while he is in hospital.

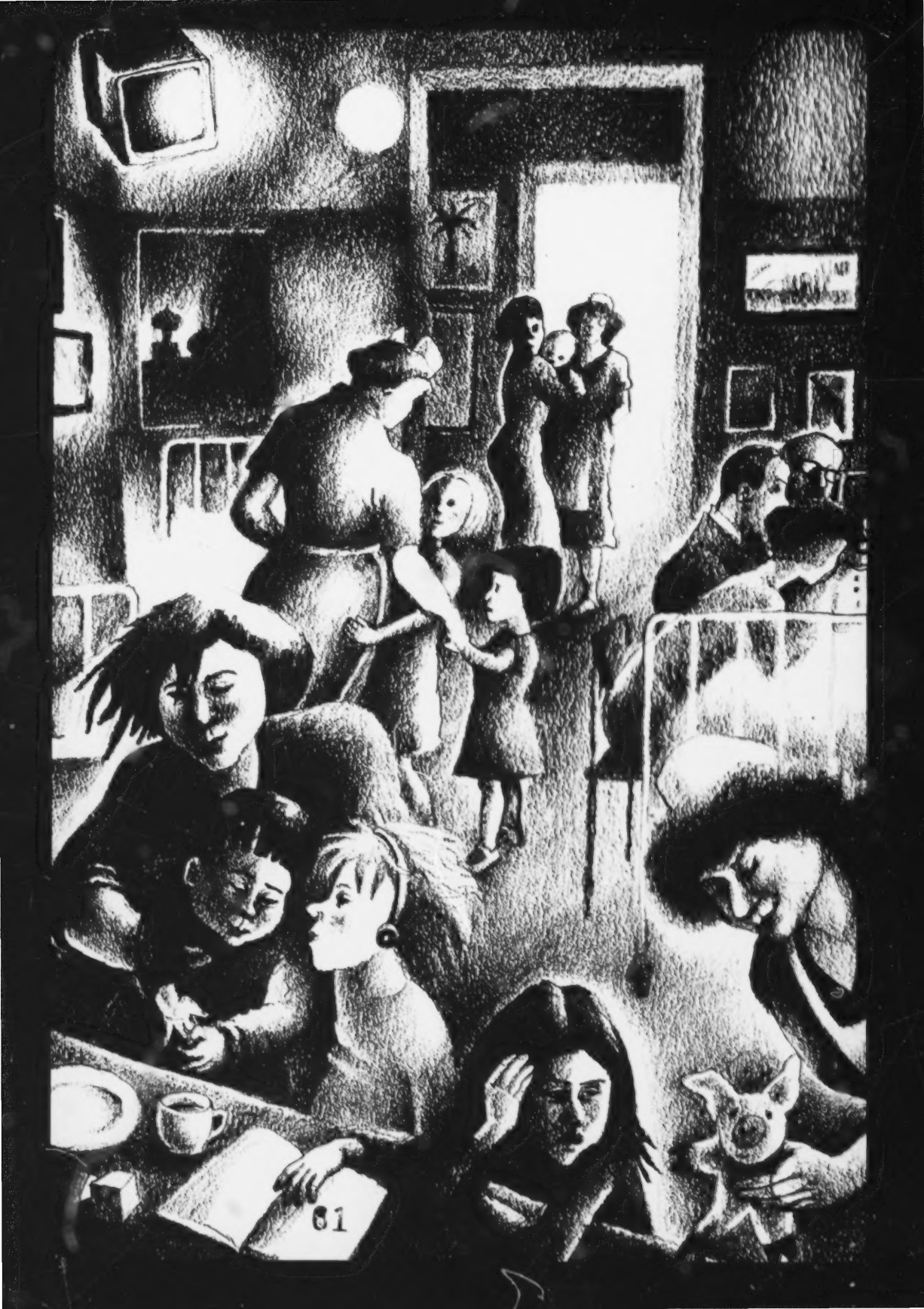
The importance of bringing the child's own toys and clothes is recognized by the great majority of units surveyed, since 23 of the units allow children to bring their own toys and 20 allow their own clothes.

It is important to prepare the child before medical procedures are carried out: 4 of the units prepare the child for procedures by means of puppet play, another 4 use books and/or pictures and 7 give oral explanations. Unfortunately half of the units give no preparation at all. It is also important for the child to receive support after a procedure to work through any frightening experience: 7 of the units have a special play programme after the procedures for this purpose, but 17 of the units have no programme to give children such support.

Kindergarten teachers and school teachers are essential members of the team in a hospital where children are located: 11 of the units surveyed have kindergarten teachers assigned to the unit itself, while another 3 may call on kindergarten teachers assigned to the whole hospital; 11 of the units have access to school teachers who are assigned not to the unit but to the hospital as a whole. Thus, about half of the hospitals in the survey do not provide these teachers.

Suggestions for change made by the respondents

As most of the hospitals visited were built before it was known that children benefit from having their parents with them it is not surprising that most of the respondents (namely 20) indicated the need for environmental changes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such as more space and a more homely environment. It is likewise not surprising that 17 of the respondents suggested organizational changes, mostly the need for more staff. The fact that only 5 of the respondents suggested more in-service education for staff indicates that the present staff in these hospitals are themselves unaware of some of the serious weaknesses in daily care that were uncovered by this survey. This suggests that improvement in daily care will not result simply from increasing the number of staff, but that this must also be accompanied by more in-service education in the principles of care of children in hospital. Only one respondent mentioned the important issue of developing alternatives to hospital care, again demonstrating the need for more in-service education of staff. Only one respondent suggested educational materials for paediatric care—this seems to be timely.

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Recommendations

This study has shown that the care of children in hospital is still far from ideal. The recommendations made over the last three decades, and described in Chapters 2 and 3, about how to care for children in hospital still need to be taken up in many countries. Listed here are those recommendations that seem most urgent and most neglected.

Official policies, laws and regulations

As about half the children in the European Region spend some time in hospital and their stay must be carefully managed if their development is not to suffer, Member States should have official policies, supported where appropriate by laws and regulations, as part of their overall health programmes to protect the health of children and families when a child goes to hospital.

These policies, laws and regulations should take into account at least the following recommendations.

1. A parent should be able to care for a child in hospital without losing his or her job or income.

2. Policies should encourage alternatives to hospital admission whenever possible, so that children are admitted to hospital only when their particular illness demands treatment not available elsewhere.

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3. Official policy should guarantee open visiting (24 hours a day) by the parents of a child in hospital. Policy should ensure that parents can room-in with their child in hospital. Regulations should encourage the participation of parents in the care of their child in hospital.

4. Children under 15 years of age should be admitted to children's units only, regardless of the illness or medical problems of the child (unless a child needing highly specialized care could get it in a children's hospital only by going too far from home).

5. Official policies, supported by laws and regulations, should provide for adequate education and play therapy for the child in hospital including the adequate training of teachers and play therapists.

6. Official policy should establish the goal of individualized care for every child in hospital and should specify adequate nursing staff as one of the first requirements.

Daily care practices in hospital

1. The education of nurses working with children in hospital should include paediatric nursing, adult nursing, knowledge of family dynamics, knowledge of psychosocial risks for the child in hospital and the family, and the specific needs of adolescents.

2. Unless it is an emergency admission, all children and their families should be prepared for the stay in hospital before admission.

3. Visiting for parents should be free (i.e. 24 hours a day). Siblings, other relatives and friends should also be encouraged to visit.

4. Rooming-in facilities for a parent should be provided and be free of charge.

5. Kindergarten teachers, school teachers, play therapists and family social workers should be available to all units where children are admitted.

6. Parents should be informed about the care and progress of their child and in every way possible be supported during their stay. Parents should be encouraged to participate in the care of their child, including being present at medical procedures.

7. Before discharge parents should be instructed about the follow-up care of their child, including potential behavioural problems in the child and his or her siblings.

8. Follow-up of the child and family in the community through health visitors, public health nurses or others should be available to all units that admit children.

9. Every child should have an individual nurse assigned during his or her stay in hospital and should be allowed to bring his or her own toys, clothes or other personal articles to the hospital.

10. Before any medical procedure the child should be prepared through explanations and/or demonstrations appropriate to the developmental stage of the child. Play as a means of working through frightening experiences should be offered to the young child after any medical procedure.

11. Our understanding of the needs of the child in hospital and the family, and the type of care that should therefore be provided, needs continuing research and evaluation. Hospital units that admit children should have a continuing evaluation process that includes feedback from the children and family about their good and bad

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experiences during their stay in the unit. Hospital staff must continually reassess the care they give to children, and all hospital staff—especially the nursing staff—must be included in this reassessment process. The contribution of nursing education and nursing practice to the care of children in hospital should be further investigated by nurses.

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Annex 1

Questionnaires administered to government representatives and nurses

Form A: official country regulations and laws

Date _____
Country _____
Reg. _____
Law _____
Int. beg. _____
Int. fin. _____
Total time _____

Purpose: The purpose of this instrument is to clarify and verify, with an official governmental representative, the contents of written policies, regulations and laws.

Direction: Complete each item by reading the question scheme to the respondent. Leave no item blank.

Section I: Demographic data of interviewee.
A. Title _____
B. Area of expertise _____
C. Years of current position _____

Section II:
A. Admission policies, regulations and laws.
1. How many children under 12 years are admitted yearly?
a. _____ b. _____ %
2. Of this number, how many are admitted to
a. paediatric units _____ _____ %
b. non-paediatric units _____ _____ %

3. What criteria are used a. _____
   b. _____
   c. _____
   d. none

4. Under what conditions are alternatives used?
   a. _____
   b. _____
   c. _____

B. Parental involvement.

5. Are parents by law permitted to stay away from work to take care of a sick child?
   a. the mother _____
   b. the father _____
   c. when a child is hospitalized _____
   d. when a child is cared for at home _____

6. For how many days a year? _____ days

7. What is the policy regarding participation of parents?

   _____

C. During hospitalization.

8. What is the average stay for a child in hospital?
   _____ days

9. How many hours a week is visiting allowed? _____ hours

10. Who can visit?
    a. parents _____
    b. siblings _____
    c. other family _____
    d. friends _____

11. Is there an educational programme for school children?
    a. from the first day _____
    b. after _____ weeks/days of admission
    c. no reg./law existing _____

12. Is there a play programme in all hospitals?
    a. in paediatric units _____
    b. in adult units, where children are admitted _____
    c. the hospital decides, no reg./law _____

13. What is the policy regarding number of children per nurse? _____

Form B: nurse interview

Date _____
Institution _____
_____
Country _____
Int. beg. _____
Int. fin. _____
Total time _____

Purpose: The purpose of this instrument is to clarify and verify, with a first level nurse, daily nursing care practice.

Direction: Complete each item by reading the question scheme to the respondent. Leave no item blank.

Section I: Demographic data of interviewee.

A. Title _____
B. Area of expertise _____
C. Years of current position _____
D. Paediatric training
theoretical _____
practical _____

Section II:

A. Hospital environment.

1. Size of institution _____ beds
2. Number of specialties _____
3. Type of unit
   a. paediatric _____
   b. non-paediatric, but only children admitted _____
   c. non-paediatric, with special rooms for children _____
   d. non-paediatric, with no special rooms for children _____
4. Age of children admitted here ____ to ____
5. Number of beds in this unit _____
   a. for children only _____
   b. for adults only _____

B. Organization of unit.

6. How is the child/family prepared before admission?
   a. leaflet mailed to the family before admission _____
   b. leaflet given to the family after admission _____

c. visiting the unit _____ days before admission _____
d. other, which? _____

7. What are visiting regulations?
   a. free visiting _____
   b. _____ hours/day
   c. _____ hours/week
8. Who can visit?
   a. parents _____
   b. siblings _____
   c. other family _____
   d. friends _____
9. Are parents admitted with the child?
   a. encouraged to _____
   b. allowed to, when asking _____
   c. not allowed _____
10. If parents are allowed rooming-in, which facilities do you offer?
    a. bed _____
    b. armchair _____
    c. sitting room _____
    d. meals _____
    e. kitchen _____
    f. others, which? _____
11. Are there available
    a. play room _____
    b. out-door play area _____
    c. school room _____
    d. toys _____
12. Are those areas accessible for
    a. children in wheelchairs _____
    b. children in beds _____
13. Are there any special child-proof measures at
    a. staircases _____
    b. windows _____
    c. doors _____
    d. other places, which? _____
14. Where are children placed for care in case of need for isolation or intensive care?
    a. in a special room in this unit _____
    b. outside this unit _____
15. Under which conditions is the social worker called?
    a. financial problems in the family _____
    b. other problems, which? _____
    c. none available _____

C. Emotional support to the parents.

16. Are the parents currently informed of the nursing care plan?
    a. only if they are present _____
    b. only before major procedures (which) _____
    c. no _____
17. Is there a special time for parents to talk to the nurse?
    a. always possible _____
    b. twice a day _____
    c. once a day _____
    d. no _____
18. In case of rooming-in, is the parent encouraged to
    a. dress and feed the child _____
    b. be present during medical procedures _____
    c. take over part of the nursing care (which) _____

    _____
19. What is done, if the parents do not visit even if it is possible? Describe _____
20. How is the family prepared before discharge of the child?
    a. according to the child's behaviour _____
    b. according to siblings _____
    c. contact with health visitor _____
    d. other _____

D. Emotional support to the child.

21. Is each child assigned to a special substitute mother?
    a. nurse _____
    b. other, whom? _____
    c. no _____
22. Is it possible for a child
    a. to bring own toys _____
    b. to wear own clothes _____
23. How is a child prepared before the following procedures?
    a. blood test _____
    b. X-ray _____
    c. anaesthesia _____
    d. injections _____
    e. other, which? _____

    _____
24. Is there a special play programme after the same procedures?
    a. _____
    b. _____
    c. _____

d. _____

e. _____

25. Is there a play therapist assigned to this unit?
    a. yes, education _____ _____ hours/week
    b. no _____
26. Is there a school teacher assigned to this unit?
    a. yes _____ __ hours/week
    b. no _____
27. If you were going to make changes to the care of children in this unit, what would you suggest? _____

_____

_____

_____

_____

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Going to hospital can be a difficult experience for a child and many ways have been found to help children cope with it with the minimum of suffering. Unfortunately many countries still do not put this knowledge into practice and there are still hospitals where parents cannot even visit their children, where the children have no play or educational facilities and where nothing is done to explain to children what is being done to them. Nursing staff are often woefully ill equipped to understand the special needs of children in hospital. The author of this book reviews the studies that have been made since the 1950s about the effect going to hospital can have on a child. She reiterates the conclusions they came to and the recommendations they made. She then describes a study she herself carried out in nine European countries to see how the theory matched the practice. Finally she analyses what she found and concludes with what *still* needs to be done to prevent children from finding a hospital stay an upsetting and lastingly damaging experience.

World Health Organization
Regional Office for Europe
Copenhagen